DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155362	B. WIN	G		09/01/2	011
	PROVIDER OR SUPPLIER		•	8800 VI	ADDRESS, CITY, STATE, ZIP CODE IRGINIA PLACE LLVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID		PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0000	Complaints IN00 IN00095771. This visit was in Survey Revisit (F. Recertification ar Survey completed Complaints IN00 IN00095771- Suldeficiencies relations of the survey dates: Au 2011 and Septem Facility number: Provider number: AIM number: 1 Survey Team: Kelly Sizemore, 1 Sheila Sizemore, 31, 2011 and Septem Marcia Mital, RN 2011) Janelyn Kulik, Ri and 31, 2011)	conjunction with a Post PSR) to the and State Licensure d on 07/20/11. 1094662 and bestantiated, Federal/State ed to the allegations are 26, and F323. 11gust 28, 29, 30, and 31, alber 1, 2011 1000253 155362 100266660 RN-TC RN (August 29, 30, and ottember 1, 2011) N (August 28, 30, and 31, alber 1, 2011) N (August 28, 30, and 31, alber 1, 2011) N (August 28, 30, and 31, alber 1, 2011) N (August 28, 30, and 31, alber 1, 2011) N (August 28, 30, and 31, alber 1, 2011) N (August 28, 30, and 31, alber 1, 2011)	FC	0000	Preparation, submission and implementation of this Plan of Correction does not constitute admission of or agreement with facts and conclusions set forth on the survey report. Or Plan of Correction is prepare and executed as a means to continuously improve the quaterial of care and to comply with all applicable state and federal regulatory requirements.	of te an vith t Our od	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QBDY11

Facility ID:

000253

If continuation sheet

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155362		A. BUILDING B. WING		COMP	COMPLETED 09/01/2011	
	PROVIDER OR SUPPLIER		STREET A 8800 VI	ADDRESS, CITY, STATE, ZIP CODE RGINIA PLACE LLVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG	Census bed type: SNF/NF: 156 Total: 156 Census payor typ Medicare: Medicaid: Other: Total: 1 Sample: 14 These deficiencie cited in accordan	be: 20 117 19 56 es reflect state findings ace with 410 IAC 16.2. completed on 9/6/2011 by	TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155362	1			09/01/2	011
			B. WINC		ADDRESS CITY STATE ZIR CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
OOLDEN	LLIVING OFNITED	MEDDULVULE			RGINIA PLACE		
GOLDEN	I LIVING CENTER-	MERRILLVILLE		MERKII	LLVILLE, IN46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	T .	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0225	,	not employ individuals who					
SS=D		guilty of abusing, neglecting,					
	•	idents by a court of law; or					
		g entered into the State					
		y concerning abuse, neglect,					
		esidents or misappropriation					
	of their property; and report any knowledge it has of actions by a court of law against an						
		would indicate unfitness for					
		e aide or other facility staff to	1				
		de registry or licensing					
	authorities.						
	The facility must e	ensure that all alleged					
		g mistreatment, neglect, or					
		njuries of unknown source					
		tion of resident property are					
	•	tely to the administrator of					
		other officials in accordance					
		bugh established procedures					
	agency).	state survey and certification					
	agency).						
	The facility must h	nave evidence that all					
		are thoroughly investigated,					
	_	further potential abuse while					
	the investigation is						
		nvestigations must be					
	•	ministrator or his designated					
		d to other officials in					
		State law (including to the					
		certification agency) within 5					
		ne incident, and if the alleged					
	action must be tak	d appropriate corrective	1				
	action must be lar	CII.	EO	225	F225 Resident #B no longer	r	09/16/2011
	D 1 1		102	²	resides at the facility. No oth		09/10/2011
	Based on record review and interview, the			residents have been found to			
	facility failed to	complete a thorough			have injuries of unknown original		
	investigation for	injuries of unknown			that have not been reported	•	
	_	to notify ISDH (Indiana	1		accordance with State law a		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155362	B. WIN			09/01/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
COLDEN	I LIVING CENTER-I	MEDDILIVILLE		1	RGINIA PLACE LLVILLE, IN46410		
				L .			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)				TE	COMPLETION DATE
IAG			+	IAG	established procedure. Any		DAIL
	State Department of Health) of the injuries in a timely manner for 2 of 3				residents found to have an in	njury	
	residents reviewe	-			of unknown origin will be		
					thoroughly investigated by t		
		in a total sample of 14.			ED or designee and promptl reported to the ISDH utilizing	-	
	(Resident #B and	1 #C)			guidelines of the ISDH titled	, ii ie	
	Findings in sleeds				"Reportable Unusual		
	Findings include				Occurrences." Staff has be	en	
	1 Dogidant #Dla	manand rever marriages d an			inserviced on the correct reporting procedures.All alle	ned	
	1. Resident #B's record was reviewed on 08/30/11 at 10:25 a.m. The resident's				violations involving mistreatr		
					neglect, or abuse, including	,	
	diagnoses included, but were not limited				injuries of unknown source a		
		eopenia, iron deficiency			misappropriations of residen	t	
	anemia, and anoi	rexia with weight loss.			property will be reported immediately to the ED of the		
		~			facility and to other officials i		
	'	S Assessment, dated			accordance with State law a		
	· ·	ed the resident had a			established procedures. All		
	cognition score of	of 5 (impaired).			bruises of unknown origin wi submitted to the QA&A for re		
					and recommendations. After		
	A laboratory test				months if 100% compliance		
		ident's prothrombin time			noted then the QA&A comm	ittee	
	`	me) was 19.4 (normal			will make recommendations		
	20.7-30.5) and th	ne INR (international			whether to continue. Date of compliance is designated as		
	normalized ratio) (measures clotting time)			September 16, 2011.		
	was 1.92 (norma	1 2.00-3.00)					
	A physician's ord	ler, dated 08/19/11,					
	indicated to give	Coumadin (blood					
	thinner) 1 milligi	ram every day.					
		137					
	The resident's Nurses' Notes indicated: 08/23/11 at 4:48 a.m., "CNA pointed out resident has a large bruise to left lower						
		em (centimeter) (l)					
	(length) x 4.5 cm	(w) (width). Resident	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				
		155362	B. WIN			09/01/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SOLI EIER			1	IRGINIA PLACE		
GOLDEN	I LIVING CENTER-I	MERRILLVILLE		MERRII	LLVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ow it happenedNo					
	swelling noted	."					
	09/22/11 -4 6:26	!! A 11. 1					
		a.m., "Added note:					
	resident's bruise is purple" A facility investigation of the bruise, dated 08/23/11 at 5 a.m., indicated the						
		leg was purple, and the					
		ble to explain how the					
	bruise was obtained. The investigation						
		vas no swelling and no					
		ns of pain when the leg					
	1	he investigation indicated					
	the facility had in	_					
	members. There						
		n the investigation to					
		been determined how the					
	bruise had occur						
	There was a lack	of documentation to					
	indicate the bruis	se had been reported to					
	the ISDH, until 0	08/25/11 at 6 p.m., when					
	the resident was	assessed to have a left leg					
	deformity.						
		iew on 08/30/11 at 10:40					
	I	strator indicated she had					
		large bruise area because					
	the resident was	on a blood thinner.					
		iew on 08/30/11 at 11:25					
	I	strator indicated she felt					
	the bruise was du	ue to the Coumadin and					

PRINTED: 09/20/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
THETETAL	or conduction	155362	A. BUII			09/01/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				RGINIA PLACE		
	I LIVING CENTER-I			MERRII	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
1710		ruise needed to be		1710	•		DATE
		she attributed the size of					
	the bruise to the						
	the orange to the community						
	 During an intervi	iew on 08/30/11 at 2:05					
	p.m., the Administrator indicated she						
	. .	se on 8/25/11, when there					
		racture of the leg and not					
	within 24 hours.						
	During an interview on 08/31/11 at 9:25 a.m., the Corporate Regional Manager						
	indicated the fact	ility could not determine					
		oruise so they felt it was					
	from the Couma	din.					
	2. Resident C's r	record was reviewed on					
	8/30/11 at 9:45 a	.m. Resident C's					
	diagnoses includ	ed, but were not limited					
	to, dementia, seiz	zure disorder, and					
	hypertension.						
		F RESPONSIBILITY					
		ABSENCE FROM THE					
		n indicated the resident					
		f the facility on 8/6/11 at					
		amily member. It lacked					
		he resident returned to					
	the facility.						
	Nurse's notes als	o lacked a date and time					
		ned to the facility.					
		· · · · · · · · · · · · · · · · · · ·					
	The Nurses' Note	es indicated:					

000253

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155362	B. WING		09/01/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	N LIVING CENTER-I	MERRII I VII I E	I	/IRGINIA PLACE RILLVILLE, IN46410	
				1	1 275
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL.	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
PREFIX TAG	8/7/11 at 7:57 p.i (resident) noted of slightly red area cm (centimeters) red area to lt (left cm)Assessmen No itching or dist notified, continuous aware" 8/8/11 at 4:09 a.r. red swollen area swelling to rt for forehead subsidiant swelling to rt for forehead subsidiant swollen area swelling to rt for forehead swollen area swelling to rt for forehead subsidiant swollen area swelling to rt for forehead subsidiant swollen area swollen area swelling to rt for forehead subsidiant swollen area swollen area swollen areas when staff interviews in staff interviews i	m., "Situation: Res with slightly swollen, to rt (right) forehead (1.5 x (by) 1 cm) & swollen t) upper cheek (2 cm x 1 t: No open area noted. comfort notedMD to to monitor. Family m., "Res continues with to lt upper cheek & slight the shead. Swelling to rt ing" .m., "staff to monitor areas to the forehead and	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
	himself on the fo	ot of the bed, would not			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	COMPL		
THEFTERN	or conduction	155362	- 1	LDING		09/01/2	
		1.55002	B. WIN		DDRESS, CITY, STATE, ZIP CODE	1 3370 172	- · ·
NAME OF F	PROVIDER OR SUPPLIER	₹		1	RGINIA PLACE		
GOLDEN	I LIVING CENTER-	MERRILLVILLE		1	LVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
IAG			+	TAG	DIA TOLENCI)		DATE
	-	d." The investigation					
	lacked a family interview and did not						
	nave a final cond	clusion of what happened.					
	During an interv	iew with the DoN					
ı	_	sing), on 8/30/11 at 11:30					
	*	ed when she assessed the					
		11 in the morning, "It					
	wasn't a bug bite	e, it was more of an					
	abrasion on the l	eft cheek bone." She					
	indicated they were not able to determine						
	what happened and no one had interviewed the family.						
		AL REPORT," attached					
		eport, indicated the report					
	was sent to ISDI	H on 8/9/11 at 7:28 p.m.					
	During an interv	iew with the					
	-	n 8/31/11 at 10:35 a.m.,					
	•	report was not sent until					
	8/9/11.	•					
	This federal tag	relates to complaints					
	IN00094662 and	I IN00095771.					
	3.1.28(a)						
	3.1-28(c) 3.1-28(d)						
	3.1-28(u)						

PRINTED: 09/20/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	00	COMPLETED	
		155362	A. BUILDING B. WING	09/01/2011	
	PROVIDER OR SUPPLIER		8800 VI	ADDRESS, CITY, STATE, ZIP CODE IRGINIA PLACE LLVILLE, IN46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	written policies and mistreatment, neg and misappropriat Based on record facility failed to investigating injurand failed to notin Department of H of 3 residents rev	,	F0226	F226 Resident #B no long resides at the facility. No otheresidents have been found to have injuries of unknown orithat have not been reported accordance with State law a established procedure. Any residents found to have an information of unknown origin will be thoroughly investigated by the or designee and promptly reported to the ISDH utilizing guidelines of the ISDH titled "Reportable Unusual"	her o gin in nd njury ne ED

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QBDY11 Facility ID:

000253

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155362		LDING	00	09/01/2	
		100002	B. WIN		A DDDEGG CITY GTATE ZIR CODE	03/01/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-	MERRILLVILLE		1	LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
TAG	1. Resident #B's 08/30/11 at 10:2 diagnoses includ to, dementia, ost anemia, anorexia A Quarterly MD 07/07/11, indicate cognition score of A laboratory test indicated the residence (blood clotting to 20.7-30.5) and the normalized ratio was 1.92 (normal A physician's ordinated to give thinner) 1 milling The resident's No 08/23/11 at 4:48 resident has a laranterior leg, 13 of (length) x 4.5 cm does not know his welling noted	ident's prothrombin time ime) was 19.4 (normal me INR (international) (measures clotting time) at 2.00-3.00) der, dated 08/19/11, coumadin (blood ram every day. urses' Notes indicated: a.m., "CNA pointed out rege bruise to left lower cm (centimeter) (1) in (w) (width). Resident ow it happenedNo ."		TAG	Occurrences." Staff has been inserviced on the correct reporting procedures. All alleviolations involving mistreatm neglect, or abuse, including injuries of unknown source and misappropriation resident property will be repoimmediately to the ED of the facility and to other officials in accordance with State law and established procedures. All investigations of bruises of unknown origin will be submit to the QA&A for review recommendations. After six months if 100% compliance in noted then the QA&A commit will make recommendations whether to continue. Date of compliance is designated as September 16, 2011.	en eged nent, s of orted n d itted is ttee	DATE
	A facility investi	action of the bruise					
	A facility investi	gation of the bruise,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:					(X3) DATE : COMPL			
11.12 12.11.	or condition.	155362				09/01/2		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF 1	PROVIDER OR SUPPLIER			1	IRGINIA PLACE			
GOLDEN	N LIVING CENTER-I	MERRILLVILLE		MERRILLVILLE, IN46410				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION	
TAG	ŧ	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		t 5 a.m., indicated the						
		leg was purple, and the						
	resident was unable to explain how the							
	bruise was obtained. The investigation							
		vas no swelling and no						
		ns of pain when the leg						
	1	he investigation indicated						
	the facility had in							
	members. There							
	1	n the investigation to						
	indicate how the bruise had occurred.							
		of documentation to						
		se had been reported to						
	the ISDH, until 0	08/25/11 at 6 p.m., when						
	the resident was	assessed to have a left leg						
	deformity.							
	. During an intervi	iew on 08/30/11 at 10:40						
	1	strator indicated she had						
	1 '	large bruise area because						
	1 ^	on a blood thinner. She						
		lowed the facility's policy						
	and procedure.	lowed the facility's policy						
	and procedure.							
	An untitled polic	y and procedure, dated						
	01/04, and receiv	• •						
	· ·	current, indicated,						
		ill report resident						
	1	acerations meeting the						
		a: (**excluding residents						
	1	agulant Therapy)						
	1	ses 10 cm or larger on						
		Residents receiving						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP: 09/01/2	LETED	
	PROVIDER OR SUPPLIER		8800 V	ADDRESS, CITY, STATE, ZIP COI IRGINIA PLACE LLVILLE, IN46410	DE	
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION
PREFIX TAG	Anticoagulant T by the facility in contusions/bruis will only be reported that the latthe Anticoagular During an interval.m., the Administ the bruise was didn't think the bruise to the During an interval.m., the Administ the bruise to the During an interval.m., the Administration of the bruise to the During an interval.m., the Corported the bruise to the During an interval.m., the Corported the bruise to the Corported the fact a reason for the from the Coumal 2. Resident C's and diagnoses including the fact and the fact	herapy will be monitored relation to ing Contusions/bruising orted if assessment bruising was not related to not Therapy." iew on 08/30/11 at 11:25 istrator indicated she felt ue to the Coumadin and bruise needed to be as he attributed the size of Coumadin. iew on 08/30/11 at 2:05 istrator indicated she se when there was a se of the leg on 8/25/11 4 hours. iew on 08/31/11 at 9:25 istrator indicated she se when there was a se of the leg on 8/25/11 4 hours. iew on 08/31/11 at 9:25 istrator indicated she se when there was a se of the leg on 8/25/11 4 hours. iew on 08/31/11 at 9:25 istrator indicated she se when there was a se of the leg on 8/25/11 4 hours. iew on 08/31/11 at 9:25 istrator indicated she se when there was a se of the leg on 8/25/11 4 hours.	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE PROPRIATE	COMPLETION DATE
	hypertension. A "RELEASE O	zure disorder, and F RESPONSIBILITY F ABSENCE FROM THE				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER				NSTRUCTION 00	(X3) DATE S COMPL		
		155362	A. BUILDI B. WING	ING		09/01/2	011
NAME OF I	PROVIDER OR SUPPLIER		1		DDRESS, CITY, STATE, ZIP CODE RGINIA PLACE		
GOLDEN	I LIVING CENTER-I	MERRILLVILLE			LVILLE, IN46410		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	l l	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	l l	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
		n indicated the resident					
	1	f the facility on 8/6/11 at ted a date and time the					
	resident returned						
	N. 1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
		o lacked a date and time med to the facility.					
		•					
	Nurses' notes on times indicated:	the following dates and					
	times mulcated.						
	1	m., "Situation: Res					
	l ` ′	with slightly swollen,					
	1 ~ ~	to rt (right) forehead (1.5 x (by) 1 cm) & swollen					
		t) upper cheek (2 cm x 1					
	,	t: No open area noted.					
		comfort notedMD					
	notified, continue	e to monitor. Family					
	aware"						
	8/8/11 at 4:09 a.r	n., "Res continues with					
	red swollen area	to lt upper cheek & slight					
		ehead. Swelling to rt					
	forehead subsidir	ng"					
	8/8/11 at 12:34 p	.m., "staff to monitor					
	red and swollen	areas to the forehead and					
	left cheek						
	A "VERIFICATI	ON OF					
	INVESTIGATIO	N" form, dated 8/7/11 at					
		ted it was the initial and					
	follow-up report.	It indicated the resident					

000253

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR	VEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPLETE	D
		155362	B. WIN			09/01/2011	
			P. (12)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	IRGINIA PLACE		
	I LIVING CENTER-I	MERRILLVILLE		MERRII	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	.	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE CO	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT		DATE
	was unable to be interviewed due to						
	1 ~	s. Staff interviews					
		ident went out to a family					
	_	ot have the reddened or					
		nen he returned, but in the					
	· ·	ed areas on forehead and					
	left cheek were n	noted during a.m. care.					
	Staff interviews i	indicated they might have					
	been "bug bites"	or "could have bumped					
	himself on the fo	oot of the bed, would not					
	lay at head of be	d." The investigation					
	lacked a family i	nterview and did not					
	have a final conc	clusion of what happened.					
		• •					
	During an intervi	iew with the DoN					
		sing), on 8/30/11 at 11:30					
	1 '	ed when she assessed the					
	· ·	n't a bug bite, it was more					
	· ·	the left cheek bone."					
		ey were not able to					
		nappened and no one had					
	interviewed the f						
	interviewed the I	ammy.					
	A "FAX JOURN	AL REPORT," attached					
	to the incident re	port, indicated the report					
		H on 8/9/11 at 7:28 p.m.					
		1					
	A facility policy	titled, "REPORTABLE					
	1 ' '						
	UNUSUAL OCCURRENCES," revised 1/25/06 and received as current by the						
		•					
	Administrator, on 8/30/11 at 11:30 a.m., indicated "PROCEDURE: Occurrences						
	· -	Facilities are required by					
	i iaw to report unu	isual occurrences within	ı				

000253

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
		155362	A. BUILI B. WING			09/01/2	
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R.			RGINIA PLACE		
GOLDEN	I LIVING CENTER-	MERRILLVILLE		MERRIL	LVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		rrence to the Long Term		TAG	DEFICIENCE (DATE
		the facility must ensure					
	that all alleged v	-					
	involvinginjuri						
		rtedINJURIES OF					
	•	OURCE: An injury should					
		ın injury of unknown					
		h of the following					
	conditions are m	et: The source of the					
	injury was not ol	oserved by any person or					
	the source of inju	-					
	-	resident; AND The					
		ous because of the extent					
		he location of the					
		TY REPORTING AND					
		ON INSTRUCTIONS:					
		ntact the ISDH (Indiana					
	•	t of Health)within 24					
	exists"	mining a situation					
	exists						
	During an interv	iew with the					
	_	n 8/31/11 at 10:35 a.m.,					
	· ·	report was not sent until					
	8/9/11.	report was not some until					
	This federal tag	relates to complaints					
	IN00094662 and	-					
	3.1-28(a)						

PRINTED: 09/20/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155362		A. BUILDING	00	COMPLETED 09/01/2011	
	PROVIDER OR SUPPLIER		8800 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA PLACE ILLVILLE, IN46410	1
GOLDEN	LIVING CENTER-I	WERRILLVILLE	IVIERRI	LLVILLE, IN46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=G	environment rema hazards as is poss receives adequate devices to prevent Based on record facility failed to e environment was related to transfer mechanical lift w The resident was deformity of the diagnosed at the left tibia and fibu (Resident #B) Findings include A, "Facility Incid with an incident of p.m., indicated, " presented with bi	review and interview, the ensure a resident's free of accident hazards, tring a resident with a with only one assistant. assessed to have a lower left leg, which was hospital as a fractured that (lower leg bones).	F0323	F323 Resident #B no longeresides at the facility. No of residents have been found thave noted issues related to transfer via lift. All residents are transferred via the lifts that are not on therapy caseload been reviewed by an interdisciplinary team for appropriateness of lift use and number of required staff assistance. Staff have been serviced on the use of the mechanical lifts including nure of those designated for transfers lift have care plans updated include the use of a mechar lift with the assistance of two Five transfers will be audited randomly on all three shifts DNS and/or designee daily in the side of the side of the side of the shifts and or designee daily in the side of the sid	her to that hat I have f in imber sfer. ed via to nical o. d by the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QBDY11 Facility ID:

000253

If continuation sheet

Page 16 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155362	B. WIN			09/01/2	011
		1	P. (111)		ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF	PROVIDER OR SUPPLIEF	₹			RGINIA PLACE		
	N LIVING CENTER-	MERRILLVILLE			LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	+	TAG	,		DATE
	fall recently, resident is dependent for				days a week for thirty days the three transfers a day five day		
	1 *	nsfersConclusion is			week for thirty days and then		
		ely occurred from			transfers a day five days a w		
	1 ^	g in bed to elevate heel.			to ensure that the appropriat		
	With the movem	ent of the ankle to			number of staff are present.		
	reposition and th	ne dx (diagnosis) of			compliance is not observed t affected staff will be	nen	
	osteoporosis the	gentle repositioning			re-inserviced. Audits will be		
	could have resul	ted in the fracture.			submitted to QA&A for review	w for	
	Resident showed	d no signs of distress until			any noted patterns		
	positioning of th	e heel occurred at which			and/or recommendations. Af		
	1 -	served the drop in the foot			six months if 100% complian		
	1	se immediately"			noted then the QA&A will ma recommendations whether to		
					continue. Date of compliance		
	The investigation	n by the facility, date			September 16, 2011.		
	08/24/11, indicar						
	1	LPN #1 indicated the					
	1	n sitting in front of the					
		nd there was nothing					
	unusuai noi cam	ing out by the resident.					
	1	rviewed CNA #2 (CNA					
		ing the day shift on					
	08/24/11) on 08/	/26/11. CNA #2					
	indicated, she ha	nd transferred the resident					
	with the "Marisa	" lift (mechanical lift)					
	when she got the	e resident out of bed. She					
	indicated she had	d used the lift alone. She					
	indicated the res	ident had not been in any					
	1	e she was a fall risk, she					
	1 -	sident to sit by the nurses'					
	station. CNA #2 indicated nursing						
	students were in the room during the						
	transfer of the resident with the						
	mechanical lift.	STACIL WILL LIV					
	I meemamear mit.						

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	i i	E SURVEY PLETED (2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PLACE MERRILLVILLE, IN46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
	the nursing stude Instructor indicate observing care the The facility interwho had transfer bed on 08/24/11) indicated when so the resident was room and the resident was room and the resident had voice. During a telepho at 11:40 a.m., CN transferred the resident had with the indicated she had on her own. She had assisted her indicated she had a she had	cord was reviewed on 5 a.m. The resident's ed, but were not limited eopenia, iron deficiency rexia with weight loss.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	155362		LDING	00	09/01/2	
		100002	B. WIN		DDDDGG GITTY GTATE ZID GODE	03/01/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-N	MERRILLVILLE		1	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	DATE
	indicated the resi						
	with osteoarthriti	s in the right hip.					
	A, "Team Confer	ence/Patient Rounds					
	Form," signed by	the physician on					
	1	ed the resident was					
		d, a mechanical lift was					
		s, and the resident					
	required maximu						
	activities of daily	living.					
		D + Q + (14DQ)					
		imum Data Set (MDS)					
	· ·	ed 11/02/10, indicated the					
		es understood others and					
		nderstood, had cognitive					
	1 ~	zero (impaired), and was					
	transfers.	o or more persons for					
	transfers.						
	The Care Area A	ssessment, dated					
		ed the resident had					
	1	ining a sitting balance					
	and had impaired						
	transitions.	Č					
	The "Lift/Mobili	ty Assessment for					
	· ·	1 11/02/10, indicated the					
		t bear weight on at least					
	•	to follow simple					
	instructions, was	not able to grip with at					
		nd weighed less than 350					
	l ^	m indicated the resident					
		ni-reclined position and					
	weighed less that	n 420 pounds. The form					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155362		A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 09/01/2	ETED	
		100002	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2	
NAME OF I	PROVIDER OR SUPPLIER	2			RGINIA PLACE		
	I LIVING CENTER-			1	LVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAO		· · · · · · · · · · · · · · · · · · ·		IAG	,		DATE
	indicated the resident was a candidate for the Marisa lift and not the Sara (stand up)						
		dicated the resident					
		ff member assistance for					
	transfers.	ii iiiciiioci assistance ioi					
	danisions.						
	A quarterly clini	cal health status					
	1 1	d 07/02/11, the resident					
	· ·	lance with sitting and					
	standing.						
	A Quarterly MD	S Assessment, dated					
	07/07/11, indica	ted the resident had a					
	•	of 5 (impaired) and					
	_	ve assistance of two or					
	more for transfer						
	A care plan, date	ed 07/18/11, indicated the					
	resident was at r	isk for falls related to a					
	right below the l	knee amputation, history					
	of falls, and dem	entia. The interventions					
	included to use a	n mechanical lift for					
	transfers.						
		urses' Notes indicated:					
		a.m., "CNA pointed out					
		rge bruise to left lower					
	_	em (centimeter) (l)					
	1 ` • ′	n (w) (width). Resident					
		w it happenedNo					
	swelling noted	."					
	00/02/11	WA 11 1					
		a.m., "Added note:					
	resident's bruise	is purple"					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155362		A. BUII	LDING	NSTRUCTION 00	Ì	(3) DATE SURVEY COMPLETED 09/01/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP COD RGINIA PLACE LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	bed. Calm. Bruis	n., "Resident resting in e to Left leg unchanged. ms pain to bruised					
	this time, bruisin	a.m., "Resident in bed at g remains to left anterior noted. No swelling noted					
		p.m., "Resident up in w/c ining roomIn no					
	to bedIncreased (left lower extrem	p.m.,"Resident put back d bruising noted to LLE nity). Lower left leg w, appears broken in					
	08/24/11 at 5:55 transferredExh movement"	p.m., "Resident ibits Pain to LLE with					
	Resident #B's ho reviewed on 08/3	spital records were 80/11 at 8 a.m.					
	08/24/11 at 9:52 "possible fractufrom the nursing ecchymosis (brui	y and physical, dated p.m., indicated, are to left lower legSent home because of sing) and deformity to s confused and can not					

li ´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155362	B. WIN			09/01/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
COLDEN	I LIVING CENTER-I	MEDDII I VIII I E		1	RGINIA PLACE LLVILLE, IN46410		
					LLVILLE, IN40410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
IAG			-	IAG			DATE
		Physical ExamHt 4" (inches)Wt (weight)					
	,	· / · · · · /					
		.obeseonly looks when d. Does not follow					
	instructions or an	nswer questions"					
	Λ h a amit = 1.1 = Ω 1 .						
	•	wer leg x-ray, dated					
		oort completed on					
	•	ed, "severe bruising					
		ormity to left lower let. A					
	-	noted in the mid shaft					
	through the proxi						
	•	a of the bony structures is					
	•	racture through the					
	proximal shaft of	f the fibula is noted."					
		00/20/11 2 0 5					
	_	iew on 08/30/11 at 2:05					
	*	strator indicated the					
		nanufacturer's instructions					
	indicated one car	regiver could use the lift.					
	D since it is						
		iew on 08/30/11 at 2:15					
	* '	r of Nursing (DoN)					
		chanical lift instructions					
	•	rson could use the lift.					
		e CNA training book					
		vere supposed to be two					
		with a mechanical lift					
	transfer.						
		titled, "Mechanical Lift,					
	Hydraulic", recei						
		08/30/11 at 2:30 p.m.,					
	indicated, "PLAC	CE THE					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAIN	OF CORRECTION	155362		LDING	00	09/01/20	
		100002	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/01/2	
NAME OF F	PROVIDER OR SUPPLIER			1	IRGINIA PLACE		
GOLDEN	I LIVING CENTER-I	MERRILLVILLE		1	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		RER'S INSTRUCTIONS		IAU			DATE
		LITY MECHANICAL					
	LIFT HERE." T						
		s the only policy the					
	facility had.	is the only poney the					
	racinty naa.						
	The manufacture	r's instructions, dated					
		"Policy on Number of					
	· ·	equired for Patient					
		ny name) passive and					
	active series of li	fts are designed for safe					
	usage with one c	aregiver. There are					
	circumstances,	obesityetc. of the					
	individual that m	ay dictate the need for a					
	two-person trans	fer. It is the responsibility					
	of each facility o	r medical professional to					
		e or two person transfer					
	is more appropria	-					
		and skill level of the staff					
	members."						
	-	esource, titled, "Indiana					
		t of Health Division of					
	_	Nurse Aide Training					
	Program July 199						
	Transferring, ind	-					
	mechanical lift						
	lift"	when using a mechanical					
	1111						
	This federal tag r	relates to complaints					
	IN00094662 and	_					
	11400074002 and	111000/3//1.					

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING B. WING		LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PLACE MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		COMPLETION
	3.1-45(a)(2)					